Date: [Insert Date]

Patient Demographics

Full Name: [First Name] [Middle Initial] [Last Name]
Date of Birth: [MM/DD/YYYY]
Gender: [Male/Female/Other]
Social Security Number: [XXX-XX-XXXX]
Street Address: [Address Line 1]
City, State, Zip: [City, State, Zip Code]
Phone Number: [Phone Number]
Email Address: [Email Address]

Insurance Policy Details

Primary Insurance Carrier: [Company Name]
Policyholder Name: [Name of Main Insured]
Relationship to Patient: [Self/Spouse/Child/Other]
Member ID / Policy Number: [ID Number]
Group Number: [Group Number]
Claims Address: [Insurance Mailing Address]
Insurance Phone Number: [Provider Support Phone]

Secondary Insurance (If Applicable)

Secondary Insurance Carrier: [Company Name]
Member ID / Policy Number: [ID Number]
Group Number: [Group Number]

Emergency Contact

Name: [Contact Name]
Relationship: [Relationship]
Phone Number: [Phone Number]

Signature: _____
Date signed: _____